



I \_\_\_\_\_ authorize and direct Dr. \_\_\_\_\_ to release to The Toronto Dispensary information requested in this document. And for so doing this shall be your good and sufficient authority. This is a one-time release request. Any future requests of my medical information will require additional authorization by me

Signature

Date

\_\_\_\_\_

\_\_\_\_\_



## **APPLICATION FORM**

Phone 647.347.3030

Fax 647.347.3031

Email [info@dispensarytoronto.com](mailto:info@dispensarytoronto.com)

## **DISPENSARY ETIQUETTE**

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PLEASE SIGN AT THE BOTTOM OF THE PAGE TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTOOD THESE CONDITIONS. Failure to follow the outlined rules will cause an immediate suspension of your membership.

### **YOU MAY NOT RESELL OR SHARE ANY OF THE PRODUCT PURCHASED AT THE TORONTO DISPENSARY**

RESPECT EVERYONES PRIVACY.

CONSUME YOUR HERB RESPONSIBLY

DO NOT CONSUME YOUR MEDICINAL CANNABIS ON PREMISES OR DIRECTLY IN FRONT OF OUR PREMISES

KEEP YOUR CANNABIS AWAY FROM CHILDREN

DO NOT TRANSPORT YOUR MEDICINAL CANNABIS OUTSIDE OF CANADA

### **CAUTIONS:**

Do not drive, operate machinery, or perform other hazardous activities while using cannabis. Cannabis may cause dizziness, drowsiness, and impaired judgment.

Do not drink alcohol while using cannabis. Alcohol will increase dizziness, drowsiness, and impaired judgment.

Cannabis may increase the effects of other drugs that cause drowsiness, including antidepressants, alcohol, antihistamines, sedatives (used to treat insomnia), pain relievers, anxiety medicines, seizure medicines, and muscle relaxants.



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Do not use cannabis if you are pregnant or could become pregnant. There is some evidence that women who smoke cannabis during the time of conception or while pregnant may increase the risk of their child being born with birth defects. Pregnant women who continue to smoke cannabis are probably at greater risk of giving birth to low birthweight babies.

Do not use cannabis if you are breast-feeding a baby.

Those with a vulnerability to develop schizophrenia, such as having family history of the illness, should be strongly advised AGAINST using marijuana

NOTE: It is still illegal to possess, grow, or distribute cannabis in Canada.

### **CANNABIS SIDE EFFECTS**

Long term effects of heavy use can include:

- irritation to the lungs, risk of developing chronic bronchitis and an increased risk of developing cancer of the respiratory tract (more likely to do with smoking).
- exacerbation of pre-existing cardiovascular disease, as cannabis use significantly raises the heart rate.
- decreased concentration levels, reduced short-term memory and difficulties with thinking and learning (resolved if cannabis use stops).
- decreased sex drive in some people. Chronic use can lower sperm count in males and lead to irregular periods in females (resolved if cannabis use stops).
- dependence on cannabis - compulsive need to use the drug, coupled with problems associated with chronic drug use



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**ACKNOWLEDGEMENT:**

I have read and understood the aforementioned conditions and cautions and agree to abide by the code of conduct and cautions listed above.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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### Patient Info

Patient's First and Last Names

Date of Birth (DD/MM/YYYY)

Prescribed daily quantity of marihuana (in g/day)

Period of use (cannot exceed one year)

\_\_\_\_\_ Day(s) \_\_\_\_\_ Week(s) \_\_\_\_\_ Month(s)

### Medical Practitioner Info

Medical Practitioner's First and Last Names

Profession

M.D. \_\_\_ R.N. (E.C) \_\_\_ N.P. Doctor \_\_\_ Chiropractor \_\_\_

Province(s) Authorized to Practice in

Health Care Practitioner's License number

Business Address

Full Business address of the location at which the patient consulted the medical practitioner (if different from above)

Phone Number

Fax Number

Email address



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**By signing this document, the health care practitioner is attesting that the information contained in this document is correct and complete.**

**\*Please note that the Toronto Dispensary will contact the health practitioner's office in order to verify this information.**

**Health Care practitioner's Signature**

**Dated**

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